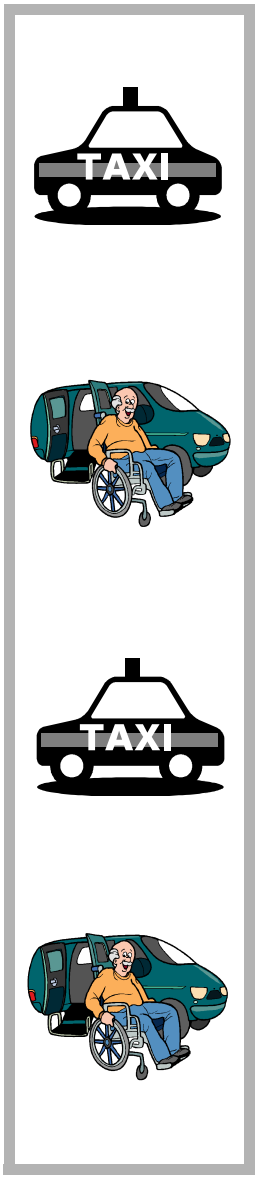

Commercial and Specialized Non-Emergency Transportation Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

August 2005

This publication supersedes all previous Commercial Transportation Services and Specialized Non-Emergency Transportation Services manuals. Published by the Department of Health and Human Services, July 2003.

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My Medicaid Provider ID Number:

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Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Authorization

All transportation requests must be authorized by the MPQHF Medicaid Transportation Center.

Mountain-Pacific Quality Health Foundation
Medicaid Transportation
P.O. Box 6488
Helena, MT 59604

(800) 292-7114 In and out of state
(800) 291-7791 Fax
ambulance@mpqhf.org E-Mail

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2	• Medicaid Information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
Department of Public Health & Human Services Website http://www.dphhs.mt.gov/index.shtml	**The official DPHHS website** • Select *A-Z Index* for links to other DPHHS sites (including Medicaid)

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for commercial transportation providers. Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type. Information about how Medicaid clients can receive transportation assistance is described in the *Personal Transportation Services* manual. All manuals are available on the *Provider Information* website (see *Key Contacts*). Clients may view the *Personal Transportation* manual on the Medicaid Client Information website (see *Key Contacts*).

The manual's table of contents and index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages, which are available on the Provider Information website (see *Key Contacts*). When replacing a page in a manual, file the old pages in the back of the manual for use with claims that originated under the old policy.

Providers are responsible for knowing and following current laws and regulations.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key*

Contacts). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the commercial and specialized non-emergency transportation programs:

- Code of Federal Regulations (CFR)
  - 42 CFR 431.53 Assurance of Transportation
  - 42 CFR 441.62 Transportation and Scheduling Assistance
- Administrative Rules of Montana (ARM)
  - ARM 37.86.2501 - 37.86.2505 Specialized Non-emergency Transportation Services

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific person or group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the *Provider Information* website (see *Key Contacts*).

Covered Services

General Coverage Principles

Medicaid covers authorized commercial transportation by ground or air to the Medicaid provider nearest the client. This chapter provides covered services information that applies specifically to commercial and specialized non-emergency transportation services. Like all health care services received by Medicaid clients, the services, providers and clients must also meet the general requirements listed in the *General Information For Providers* manual.

Transportation services are available for clients with Full or Basic Medicaid coverage. Transportation services are not available for clients with the following coverage:

- Qualified Medicare Beneficiary (QMB). This client will have a Medicaid ID card, but transportation is not covered for clients who have "QMB ONLY" coverage.
- Qualified Disabled Working Individuals Program (QDWI). This client is not issued a Medicaid ID card.
- Special Low-Income Medicare Beneficiary Program (SLMB). This client is not issued a Medicaid ID card.

To verify client eligibility, refer the *General Information For Providers* manual, *Client Eligibility* chapter.

When Medicaid covers transportation expenses to and from Medicaid clients' appointments, this type of transportation is considered non-emergency transportation and includes specialized non-emergency transportation, commercial transportation, and personal transportation.

Personal transportation (ARM 37.86.2401- 2402)

Personal transportation is for clients who do not have special transportation needs. The client or a friend or relative transports the client in a privately-owned vehicle. Personal transportation is covered when it is the least costly method of transportation. Client reimbursement is based on mileage. Clients must obtain prior authorization from the Transportation Center for this service. Clients should refer to the *Personal Transportation Services* manual for more information.

Specialized non-emergency transportation is covered only for those clients who are wheelchair bound or require transport by stretcher.

Specialized non-emergency transportation (ARM 37.86.2501-2502)

Specialized non-emergency transportation is for clients who are wheelchair-bound or must be transported by stretcher. Specialized non-emergency transportation providers must have a class B public service commission license. These providers have vehicles specially equipped to transport persons with disabilities such as wheelchair vans or stretcher vans. Clients must obtain prior authorization from the Transportation Center for this service (see the *PASSPORT and Prior Authorization* chapter in this manual).

Commercial transportation (ARM 37.86.2401-2402)

Commercial transportation is for clients who do not have special transportation requirements. Commercial transportation services are provided by air or ground commercial carrier, taxicab, or bus for a Medicaid client to receive medical care. Commercial transportation is covered only when it is the least costly form of transportation. Clients must obtain prior authorization from the Transportation Center for this service (see the *PASSPORT and Prior Authorization* chapter in this manual).

Services for children

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including transportation services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply. Medicaid also covers an attendant for children. Attendant services must be prior authorized (see *PASSPORT and Prior Authorization* chapter in this manual).

Non-covered services (ARM 37.86.2402)

Transportation services are not covered when:

- The appointment is within the client's community, and the client has access to public transportation, a personal vehicle, or a family member or friend with a personal vehicle. For example, if a client has routine access to a grocery store or pharmacy, Medicaid does not cover transportation.
- The client is determined retroactively eligible for Medicaid, and the transport occurred before retroactive eligibility was determined.
- The scheduled transport did not take place (see *When to Bill Medicaid Clients* in the *Billing Procedures* chapter of this manual).
- Transportation was provided in a state or government vehicle.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's transportation fee schedule. In addition to being listed on the fee schedule, all services provided must meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Take care to use the fee schedule that pertains to the date of service.

Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

The following are coverage rules for specific commercial and specialized non-emergency transportation services. Commercial transportation services do not include travel in a privately owned vehicle, an ambulance, or a specialized non emergency transportation vehicle. Clients must be wheelchair bound or subject to transport by stretcher to qualify for specialized non-emergency transportation. Commercial and specialized non-emergency transportation services may be covered when all of the following requirements are met:

All transports require prior authorization (see the *Authorization* chapter in this manual).

- Other methods of transportation are not available or circumstances or disability prevent the use of such transportation.
- The Medicaid client obtains Medicaid-covered services from the nearest in-state provider. Trips to out-of-state providers may be approved if it can be proven that total out-of-state expenses are less costly than in-state.
- The medical services are determined medically necessary.
- The client selects the least expensive means of transportation suitable to his or her medical needs.
- No other financial resources are available. Clients that are covered by IHS may receive Medicaid travel benefits.
- Applicable prior authorization and PASSPORT To Health requirements are met (see the *PASSPORT and Prior Authorization Requirements* chapter in this manual).

In-community travel

Transportation to obtain medical care within the community is covered when:

- The Medicaid client has a disability or circumstance that prevents the use of public transportation.
- Transportation is not available from any other source.
- The service is the least costly means of transportation available.

Nursing facility residents

For clients who reside in nursing facilities, non-emergency routine transportation (visits to physicians, pharmacy or other medical providers) is the responsibility of the nursing facility when the destination is within 20 miles of the facility. Medicaid may cover transportation costs in one of the following circumstances:

- If a client is wheelchair-bound or requires transport by stretcher.
- If a client must travel farther than 20 miles to a Medicaid covered appointment.

Presumptive eligibility (pregnant women)

Assistance with transportation is available to pregnant women during the presumptive eligibility period. The client must provide a copy of her eligibility determination letter to indicates she qualifies for presumptive eligibility because her Medicaid eligibility information may not yet be available electronically. Providers may call (800) 932-4453 to confirm presumptive eligibility (see the *General Information For Providers* manual, *Client Eligibility* chapter).

Deceased client

If a client dies en route to or during treatment outside his or her community, the cost of the client's transportation to the medical service is allowed. The cost of returning a deceased person is not covered.

Attendant

Medicaid covers one attendant for a client for whom age or disability requires attendant services.

Other Programs

The services covered in this manual are not available for clients enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

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PASSPORT and Prior Authorization Requirements

Clients Enrolled in PASSPORT To Health

Most Medicaid clients are enrolled in the PASSPORT To Health primary care case management (PCCM) program. Financial assistance may be available when medical services are provided or authorized by the client's PASSPORT provider. The Transportation Center will contact the client's PASSPORT provider to verify that the service has been approved before the trip is allowed.

Prior Authorization (ARM 37.86.2401 and 37.86.2402)

Prior authorization (PA) is when the Department (or the Department's contractor) reviews and approves the medical necessity and coverage of a service prior to delivery of the service. The Medicaid Transportation Center performs evaluation and authorization for all transportation requests (see *Key Contacts*).

If a provider transports a client without receiving a confirmation from the Transportation Center, Medicaid may not pay for the transport.

The Medicaid client must call in or fax all transportation requests to the Transportation Center before the services are provided. The Transportation Center completes the following procedures for each transportation request:

- Verifies current eligibility
- Confirms PASSPORT provider approval, if necessary
- Confirms individual appointments
- Confirms that Medicaid covers the service
- Determines the least expensive and most appropriate mode of travel

When the Transportation Center approves transport for a client, a list of approved transports is faxed to the transportation provider. The list contains client pick-up date, time, location, destination, and a procedure code and prior authorization number to use when billing Medicaid. Each transport must be approved by the Transportation Center. Therefore, if a provider transports a client without this confirmation, the provider may not receive Medicaid payment.

If a client misses or cancels a scheduled transport, he or she must obtain approval for rescheduled transports.

If a client requests transportation and the provider has not received confirmation on the transport, please refer the client to the Transportation Center (see *Key Contacts*).

Other Programs

The services covered in this manual are not available for clients enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed to Medicaid either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department, the authorizing agency, or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. However, providers may bill the client if Medicaid denies a claim because the client is not enrolled in Medicaid.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a client cancels or fails to arrive for a scheduled transport. Medicaid may not be billed for cancellations or no-show appointments either.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When Medicaid covers the service, providers must accept Medicaid rates as payment in full.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to others for that service.

Coding

Standard use of medical coding conventions is required when billing Medicaid. When the Transportation Center faxes the provider a list of approved transports, that list will contain important billing information. The following are some coding tips for billing Medicaid.

Procedure code

A procedure code is required for billing Medicaid. This code is provided by the Transportation Center on the transport confirmation list. Procedure codes are also listed in the following *Transportation Codes* table and on the Transportation fee schedule on the Provider Information website (see *Key Contacts*) and in current coding manuals (see following table of *Coding Resources*). The following is a list of valid transportation codes. These codes require prior authorization (see the *PASSPORT and Prior Authorization* chapter in this manual).

Non-Emergency Transportation Codes

Code	Use	Reimbursement	PA
Commercial Transportation - Taxicab - Provider Type 23			
A0100	Taxicab over 16 miles	per mile	Y
A0140	Taxicab under 16 miles	one way flat fee	Y
Specialized Non-Emergency Transportation - Provider Type 24			
A0100	Wheelchair van - over 16 miles	per mile	Y
A0130	Wheelchair van - under 16 miles	one way flat fee	Y

Diagnosis code

A diagnosis code is also required for billing Medicaid. Transportation providers are instructed to use diagnosis code 799.9 (unspecified or unknown cause).

Place of service

The required place of service code for taxis and wheelchair vans is 41.

Prior authorization number

A prior authorization number is also required for billing Medicaid. This code is also provided by the Transportation Center on the transport confirmation list.

Always refer to the long descriptions in coding books.

Additional billing tips

These suggestions may help reduce coding errors and unnecessary claim denials:

- Bill only for the trips or miles approved by the Transportation Center.
- Attend classes on coding offered by certified coding specialists.
- Use the correct "units" measurement on CMS-1500 claims. Unless otherwise specified, one unit equals one transport or one statute mile.

Using the Medicaid Fee Schedule

When billing Medicaid, providers should use the Department's fee schedule for transportation providers. In addition to covered services and payment rates, fee schedules contain helpful information such as authorization requirements and other information. Department fee schedules are usually updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

Two modifiers are available for use with transportation services:

- U2 is used when billing for a second trip for the same client on the same day.
- U3 is used when billing for a third trip for the same client on the same day.

Billing Tips

Before billing Medicaid, all transportation services must be authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). The CMS-1500 claim form must contain a valid Montana Medicaid procedure code, diagnosis code, and a prior authorization code. A complete list of Montana Medicaid procedure codes for transportation services are listed in the *Transportation Codes* table earlier in this chapter and on the transportation fee schedule located on the Provider Information website (see *Key Contacts*).

Billing for trips with a blanket authorization

When a provider has one prior authorization number for multiple services during a certain period of time, it is considered a blanket authorization. When billing with a blanket authorization, bill for the actual date the service was provided, with each date of service on a separate line. Span billing is not authorized (see *Definitions*). For example, a provider has a blanket authorization for 7/1 - 7/17 for 6 round trips to take the client to therapy appointments every Tuesday and Thursday morning. The services for these dates would be billed like this:

24. A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM DD YY			MM DD YY													
1	07 01 03		07 01 03			41	0	A0140		1	$20 00	2				
2	07 03 03		07 03 03			41	0	A0140		1	$20 00	2				
3	07 08 03		07 08 03			41	0	A0140		1	$20 00	2				
4	07 10 03		07 10 03			41	0	A0140		1	$20 00	2				
5	07 15 03		07 15 03			41	0	A0140		1	$20 00	2				
6	07 17 03		07 17 03			41	0	A0140		1	$20 00	2				

When more than one trip is billed on the same day, and they have different authorization numbers, bill each trip on a separate claim form.

Billing for more than one trip on the same date

When two round trips have been authorized on the same date use modifier U2, and use modifier U3 if three trips have been authorized on the same day. If you have a separate prior authorization number for each trip, bill each trip on a separate claim form. For example, if the same client shown above has also been approved for a round trip to the dentist on July 17, it would be billed like this:

24. A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM DD YY			MM DD YY													
1	07 17 03		07 17 03			41	0	A0140	U2	1	$20 00	2				

In-community travel

Transportation services can be billed for client loaded miles only. Ground trips under 16 miles are billed using the all inclusive transportation code (located on the authorization list from the Transportation Center) with one unit for one-way trips or 2 units for round trips. Trips over 16 miles are billed using the "per mileage" code, with one 1 unit per mile. Bill for only the number of trips/miles actually provided, and up to the number of trips/miles authorized by the Transportation Center.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software (available from Provider Relations)
- A claims clearinghouse
- By writing your own software using NSF 3 Montana Medicaid specifications

For more information on electronic claims submission, call the Electronic Data Interchange (EDI) Technical Help Desk (see *Key Contacts*).

The information on electronic claims submission will change with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA) in October, 2003. Providers will be notified of changes in the *Montana Medicaid Claim Jumper* newsletter.

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the provider information at the top, and the claim information for up to three claims, and mail or fax to Provider Relations.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied during processing. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • Verify that the transport has been approved by the Medicaid Transportation Center (see *Key Contacts*). • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	• Authorization is required for all transports. The authorization number must be on the claim form (see the *Authorization* chapter in this manual).
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.

Common Billing Errors (continued)	
Reasons for Return or Denial	**How to Prevent Returned or Denied Claims**
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the code from the list approved transports provided by the Medicaid Transportation Center (see *Key Contacts).* • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Other Programs

The services covered in this manual are not available for clients enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

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Completing a Claim Form

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

When completing a claim, remember the following:

- All fields shown in the following table are required.
- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Sample Claim For Commercial Transportation

Field #	Field Title	Instructions
1	Program	Check Medicaid.
2	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
10d	Reserved for local use	Enter the client's Medicaid ID number.
11d	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
21	Diagnosis or nature of illness or injury	Enter the standard diagnosis (see the *Billing Procedures* chapter, *Coding* section in this manual.
23	Prior authorization number	Enter the authorization number assigned by the Transportation Center.
24a	Date(s) of service	Enter date(s) of service for each transport.
24b	Place of service	Enter the appropriate two-digit place of service (41).
24c	Type of service	Enter Montana's type of service code 0 (zero).
24d	Procedure, service, or supplies	Enter the appropriate code for the transport. When supplying more than one transport in a day, enter the appropriate modifier (see the *Billing Procedures* chapter, *Coding* and *Using Modifiers* sections in this manual).
24e	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1) which refers to field 21 (do not enter the diagnosis code).
24f	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g	Days or units	Enter the number of units (one unit equals one transport or one mile for transports over 16 miles).
28	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
33	Provider's name, address, and phone number	Enter the provider's name, address, phone number and Montana Medicaid provider number (not UPIN).

Sample Claim For Commercial Transportation

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Goldie L.

3. PATIENT'S BIRTH DATE MM DD YY SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 799.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 21 03	07 21 03	41	0	A0140		1	10.30	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 10.30

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 10.30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 08/02/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Touchstone Taxi
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Sample Claim For Specialized Non-Emergency Transportation

Field #	Field Title	Instructions
1	Program	Check Medicaid.
2	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
10d	Reserved for local use	Enter the client's Medicaid ID number.
11d	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
21	Diagnosis or nature of illness or injury	Enter the standard diagnosis (see the *Billing Procedures* chapter, *Coding* section in this manual.
23	Prior authorization number	Enter the authorization number assigned by the Transportation Center.
24a	Date(s) of service	Enter date(s) of service for each transport.
24b	Place of service	Enter the appropriate two-digit place of service (41).
24c	Type of service	Enter Montana's type of service code 0 (zero).
24d	Procedure, service, or supplies	Enter the appropriate code for the transport. When supplying more than one transport in a day, enter the appropriate modifier (see the *Billing Procedures* chapter, *Coding* and *Using Modifiers* sections in this manual).
24e	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1) which refers to field 21 (do not enter the diagnosis code).
24f	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g	Days or units	Enter the number of units (one unit equals one transport or one mile for transports over 16 miles).
28	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
33	Provider's name, address, and phone number	Enter the provider's name, address, phone number and Montana Medicaid provider number (not UPIN).

Sample Claim For Specialized Non-Emergency Transportation

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Granny

3. PATIENT'S BIRTH DATE MM DD YY SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 99999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 799.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 21 03	07 21 03	41	0	A0130		1	10 30	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 10 30

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 10 30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Maryanne Sable 08/02/03

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Wheelchair Transporters
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often returned to the provider before they can be processed. To avoid returns and denials, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields. If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	Verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
Client name missing	Verify that the client's name is in this field and is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Prior authorization number missing	Authorization is required for all transports, and the authorization number must be listed on the claim in field 23 (see the *Authorization* chapter in this manual).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.

Other Programs

The services covered in this manual are not available for clients enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

RA notice

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

Paid claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider returning the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

Denied claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the EOB CODES column (Field 16). The EOB code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Please make necessary changes to the claim before rebilling Medicaid.

Pending claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the EOB CODES column (Field 16). The EOB code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit (see the *Billing Procedures* chapter in this manual).

If a claim was denied, please read the description of the EOB before taking any action on the claim.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

TOUCHSTONE TAXI
P.O. BOX 999
ANYTOWN MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE: 09/27/03 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	EOB CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	091803	091803	1	A0140	15.22	10.57	N	
(9) ICN	00304011250000700	999999999A							
		CLAIM TOTAL*******				15.22	10.57 (17)		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456788	DOE, JOE HENRY	092003	092003	1	A0140	15.22	0.00	N	
ICN	00304011250000800	ADDITIONAL EOB: 082 (16)							
		092003	092003	1	A0140	15.22	0.00 (17)	N	
		CLAIM TOTAL*******				15.22			048
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456787	DOE, JANE ANN	09220	092203	1	A0140	15.22	0.00 (17)	N	901
ICN	00304011250000900	092203	09220	1	A0140	15.22	0.00	N	901
		CLAIM TOTAL*******				15.22			

**********THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ABOVE**********

048 CLAIM DENIED. WE HAVE NO MEDICAID ELIGIBILITY ON FILE FOR THIS PATIENT FOR THE DATES OF SERVICE ON THE CLAIM. CHECK THE DATES OF SERVICE AND REFER TO THE ID CARD OR THE PATIENT FOR CORRECT ELIGIBILITY INFORMATION BEFORE RESUBMITTING. IF YOU HAVE DOCUMENTATION OF ELIGIBILITY OR A ONE-DAY AUTHORIZATION, YOU WILL NEED TO CONTACT THE CLIENT'S COUNTY OFFICE OF HUMAN SERVICES (WELFARE OFFICE) TO HAVE THE PROBLEM CORRECTED.

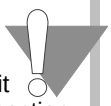
901 CLAIM SUSPENDED FOR A MAXIMUM OF 30 DAYS PENDING RECEIPT OF RECIPIENT ELIGIBILITY INFORMATION.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid (often with 3 leading zeros)
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 00 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered for this procedure or prescription.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount the provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. EOB codes (Explanation of Benefits)	A 3-digit code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with EOB code 900 require additional review before a decision to pay or deny is made.

Claims shown as pending with EOB code 901 are held while waiting for client eligibility information. The claims will be suspended for a maximum of 30 days. If eligibility information is received by Medicaid within the 30-day period, the claim will continue processing. If eligibility information is not received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.



The credit balance section is informational only. Do not post from credit balance statements.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned claims, see the *Completing a Claim* chapter. For tips on preventing denied claims, see the *Billing Procedures* chapter.

Rebill denied claims only after appropriate corrections have been made.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim on a CMS-1500 form (not the adjustment form).
- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new CMS-1500 form, or cross out paid lines and resubmit the form. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of a keying error by the claims processing contractor, contact Provider Relations.

Adjustments can only be made to paid claims.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A.* You may also order forms from Provider Relations or download them from the *Provider Information* website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.

- Enter the information from the claim form that was incorrect in the *Information on Statement* column.
- Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount.

MONTANA MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
Name: Touchstone Taxi
Street or P.O. Box: P.O. Box 999
City State Zip: Anytown, MT 59999
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00304011250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT MEDICAID NUMBER: 123456789
6. DATE OF PAYMENT: 08/15/03
7. AMOUNT OF PAYMENT $: 10.57

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	07/01/03	07/31/03
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: Maryanne Sable DATE: 09/15/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

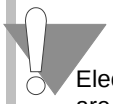
Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Electronic Remittance Advice

To receive an electronic RA, the provider must have internet access. The electronic RA is accessed through the Montana Eligibility and Payment System (MEPS) on the internet through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see the following table).



Electronic RAs are available for only six weeks on MEPS.

After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website* • Provider Relations*	Provider Relations*
Direct Deposit Sign-up Form 1199A Standard	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website* • Provider's bank	Provider Relations*
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website* • Virtual Human Services Pavilion* • Direct Deposit Arrangements*	DPHHS address on the form

* Information on this contact is available in the *Key Contacts* section of this manual.

Other Programs

The services covered in this manual are not available for clients enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP). The MHSP manual is available on the Provider Information website (see *Key Contacts*). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Appendix A:
Forms

- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Individual Adjustment Request Form***

Montana Medicaid/MHSP/CHIP Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount paid to a provider for a health care service as determined by Medicaid. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Commercial Transportation
Travel services provided by air or ground commercial carrier, taxicab, or bus for a Medicaid client to receive medical care.

Cost Sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated state agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit made to the provider that is not claim specific.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a covered service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Personal Transportation
Personal transportation is when the client or a client's friend or relative transports the client to and from medical appointments in a privately-owned vehicle. When the client meets certain requirements, he or she may get financial assistance with mileage, meals, and lodging (per diem).

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Span Billing
Billing for a range of dates of service on one line of a claim (e.g. billing for 01/01/03 - 01/30/03 on one line). Medicaid does not allow span billing for transportation claims.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Specialized Non-Emergency Transportation
Transport in a van designed for wheelchair or stretcher bound clients, which is operated by a provider with a class B public service commission license. This type of service does not require the same level of care as an ambulance, and clients using this service must have a disability or physical limitation that prevents them from using other forms of transportation to obtain medical services. Medicaid does not cover specialized non-emergency transports when another mode of transportation is appropriate and less costly.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

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